

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/07/2025	
NAME OF PROVIDER OR SUPPLIER HERITAGE ASSISTED LIVING OF YORKTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S PATRIOT DRIVE, YORKTOWN, , 47396					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00452576, IN00452327, IN00451696, and IN00448891. Complaint IN00452576 - No deficiencies related to the allegations are cited. Complaint IN00452327 - State deficiencies related to the allegations are cited at R0148, R0178, R0243, and R0245. Complaint IN00451696 - State deficiencies related to the allegations are cited at R0243. Complaint IN00448891 - No deficiencies related to the allegations are cited. Survey dates: February 5, 6, and 7, 2025. Facility number: 014281 Residential Census: 27 These State Residential Findings are cited in accordance	R 0000					

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	with 410 IAC 16.2-5. Quality review completed February 13, 2025.			
R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.	R 0148	Residents affected : 21. Maintenance Director has identified 35 rooms that need door frames repaired or replaced, of these rooms 21 are occupied. Facility is in the process of obtaining quotes to get each replaced or repaired within the next 30 days. Temporary fix to prevent cold air or water from entering the rooms that are occupied will have spray sealant foam applied until door frames are completed. This will be completed by 3/5/2025. Maintenance Director will assure that preventative maintenance schedules are followed to ensure that proper maintenance is completed to prevent such issues in the future.	03/28/2025

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Based on observation and interview, the facility failed to maintain the physical building in good repair for 1 of 4 residents reviewed for physical environment. (Resident E)

Findings include:

During an interview with Resident E on 2/6/25 at 4:34 p.m., the resident indicated a leak in her patio door allowed cold air and rain to enter her apartment whenever the weather was inclement. She had admitted to the facility in January of 2024. At that time, her visitor found a hole in the center stud of the patio doors, big enough to insert his fist. The wood was rotted and packed with leaves. The visitor had filled the hole with plastic bags and paper, then sealed it with tape. They spoke with the Director of Maintenance. To date, the patio doors continued to allow cold air to blow into Resident E's apartment. The resident indicated the west, front door of the facility did not latch properly. On windy days, the door would blow open, allowing rain, snow, or leaves to blow through the door. The only way the door would stay shut would be to lock it in place.

During random observations on 2/5/25, 2/6/25, and 2/7/25, the west front door was continuously unlatched. The

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door required only a push to enter and a pull to exit. The door knob did not have to be turned. When trying to get the door to latch, it would pop away from the latching mechanism, not engaging the latch.

During an observation on 2/7/25, at 9:30 a.m., the outside, center door jamb of Resident E's apartment was covered with tape, toward the bottom of the stud. A small section of wood above the tape was splintered and rotted. The tape extended from the patched area down onto the metal threshold of the door frame at a 90 degree angle.

During an interview with the Director of Maintenance on 2/7/25 at 11:34 a.m., he indicated there were several rotted wood sections on many of the patio doors. He estimated there were 15 to 17 locations where rotted wood needed to be replaced. He had sent pictures to the corporate liaison and was told there were plans to replace the rotted areas, but was not given a specific date or time. The building(s) were 20 to 22 years old and there were many areas that needing to be replaced. He had filled some holes with an expanding foam product to try to seal them. Cold air and rain would have to be getting through the holes, considering their sizes and

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locations.

Resident Council minutes, provided by the Activities Director on 2/5/25 at 2:15 p.m., indicated on 12/13/24, under the maintenance section, the front door was not sealing and was slamming shut. The front door was discussed again at the 1/20/25 council meeting.

A current, undated facility policy, titled "Operational Guidelines for Assisted Living," and provided by the Administrator on 2/7/25 at 9:46 a.m., indicated the following: "...Subsection B-220 - Policy Statement - The residence will be kept clean and well-maintained. This will be accomplished through a regular cleaning schedule, a preventative maintenance program, and repair or enhancement of existing structures, systems and fixtures...."

This citation relates to Complaint IN00452327.

Based on observation and interview, the facility failed to maintain the physical building in good repair for 1 of 4 residents reviewed for physical environment. (Resident E)

Findings include:

During an interview with Resident E on 2/6/25 at 4:34 p.m., the resident indicated a

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leak in her patio door allowed cold air and rain to enter her apartment whenever the weather was inclement. She had admitted to the facility in January of 2024. At that time, her visitor found a hole in the center stud of the patio doors, big enough to insert his fist. The wood was rotted and packed with leaves. The visitor had filled the hole with plastic bags and paper, then sealed it with tape. They spoke with the Director of Maintenance. To date, the patio doors continued to allow cold air to blow into Resident E's apartment. The resident indicated the west, front door of the facility did not latch properly. On windy days, the door would blow open, allowing rain, snow, or leaves to blow through the door. The only way the door would stay shut would be to lock it in place.

During random observations on 2/5/25, 2/6/25, and 2/7/25, the west front door was continuously unlatched. The door required only a push to enter and a pull to exit. The door knob did not have to be turned. When trying to get the door to latch, it would pop away from the latching mechanism, not engaging the latch.

During an observation on 2/7/25, at 9:30 a.m., the outside, center door jamb of Resident E's apartment was covered with

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tape, toward the bottom of the stud. A small section of wood above the tape was splintered and rotted. The tape extended from the patched area down onto the metal threshold of the door frame at a 90 degree angle.

During an interview with the Director of Maintenance on 2/7/25 at 11:34 a.m., he indicated there were several rotted wood sections on many of the patio doors. He estimated there were 15 to 17 locations where rotted wood needed to be replaced. He had sent pictures to the corporate liaison and was told there were plans to replace the rotted areas, but was not given a specific date or time. The building(s) were 20 to 22 years old and there were many areas that needing to be replaced. He had filled some holes with an expanding foam product to try to seal them. Cold air and rain would have to be getting through the holes, considering their sizes and locations.

Resident Council minutes, provided by the Activities Director on 2/5/25 at 2:15 p.m., indicated on 12/13/24, under the maintenance section, the front door was not sealing and was slamming shut. The front door was discussed again at the 1/20/25 council meeting.

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R 0178	Physical Plant Standards - Deficiency 410 IAC 16.2-5-1.6(b) (b) The facility shall have adequate plumbing, heating, and ventilating systems as governed by applicable rules of the fire prevention and building safety commission (675 IAC). Plumbing, heating, and ventilating systems shall be maintained in normal operating condition and utilized as necessary to provide comfortable temperatures in all areas. Based on observation and interview, the facility failed to provide an adequate heating system to provide comfortable temperatures for 1 of 3 residents reviewed for	R 0178	Resident effected: 1. Unit was replaced in resident E's room. Maintenance Director is performing temperature checks three times weekly to ensure proper temperature is maintained. Room temperature log is being maintained by Maintenance Director. Maintenance Director is also completing random temperature checks in other rooms in the building. There have been no concerns regarding temperatures in any other areas. Maintenance Director will complete temperature log three times weekly for next 30 days and weekly for next 90 days. In the future, Any concerns will be immediately addressed	02/17/2025

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environment. (Resident D)

Findings include:

During an interview with Resident D on 2/5/25 at 4:00 p.m., the resident indicated sometimes her heater worked properly, and sometimes it did not. It would randomly make popping or crackling sounds, loud enough to wake her in the middle of the night. It sounded like water hitting hot grease in a pan. The unit had been replaced once before. The Maintenance Director told her the unit worked fine. When he observed the unit, it did not perform the same as what she had described. The resident was very frustrated and felt she needed a new unit. Her room would often get very cold and the heating unit, despite making temperature adjustments, could not keep the room warm.

During an interview with Qualified Medication Aide 2 on 2/6/25 at 12:47 p.m., she indicated on January 4, 2025, during a bitterly cold spell, she observed Resident D's room to be extremely cold. She proceeded to text the Director of Maintenance about the issue. He thought the unit was probably having a hard time keeping up with the extremely cold temperatures. At that point, she created a group text to include the Administrator. She

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was confident both the Administrator and the Director of Maintenance were aware of the problem.

During an interview with the Director of Maintenance on 2/6/25 at 4:07 p.m., he indicated the reason Resident D's heating unit struggled to keep up with colder temperatures was because the resident's room was at the corner of the building and had two exterior walls (one facing north, the other facing west). The resident's heating unit had been switched out at the beginning of January, 2025. The unit sometimes made a crackling noise because water got in the back of it, causing the sound. The facility had some empty rooms and Resident D's unit could be swapped out with one of those. It was possible the resident's room might require a more powerful unit to accommodate colder conditions. Another resident's room, at the opposite corner of the building, was not experiencing the same kind of problem, probably because that residence had a fence on one of the two exposed corner walls.

Resident Council minutes, provided by the Activities Director on 2/5/25 at 2:15 p.m., indicated the following: On 1/10/25, the council had a discussion about maintenance and the need for Resident D's

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heating unit to be repaired.

A current, undated facility policy, titled "Operational Guidelines for Assisted Living," was provided by the administrator on 2/7/25 at 9:56 a.m. Under the subsection B-220, the policy indicated the following: "...The residence will be kept clean and well-maintained. This will be accomplished through a regular cleaning schedule, a preventative maintenance program, and repair or enhancement of existing structures, systems and fixtures...." and "...to assure that the residence remains a pleasant place to live...."

This citation relates to Complaint IN00452327.

Based on observation and interview, the facility failed to provide an adequate heating system to provide comfortable temperatures for 1 of 3 residents reviewed for environment. (Resident D)

Findings include:

During an interview with Resident D on 2/5/25 at 4:00 p.m., the resident indicated sometimes her heater worked properly, and sometimes it did not. It would randomly make popping or crackling sounds, loud enough to wake her in the middle of the night. It sounded like water hitting hot grease in a

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pan. The unit had been replaced once before. The Maintenance Director told her the unit worked fine. When he observed the unit, it did not perform the same as what she had described. The resident was very frustrated and felt she needed a new unit. Her room would often get very cold and the heating unit, despite making temperature adjustments, could not keep the room warm.

During an interview with Qualified Medication Aide 2 on 2/6/25 at 12:47 p.m., she indicated on January 4, 2025, during a bitterly cold spell, she observed Resident D's room to be extremely cold. She proceeded to text the Director of Maintenance about the issue. He thought the unit was probably having a hard time keeping up with the extremely cold temperatures. At that point, she created a group text to include the Administrator. She was confident both the Administrator and the Director of Maintenance were aware of the problem.

During an interview with the Director of Maintenance on 2/6/25 at 4:07 p.m., he indicated the reason Resident D's heating unit struggled to keep up with colder temperatures was because the resident's room was at the corner of the building and had two exterior walls (one

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Resident Council minutes, provided by the Activities Director on 2/5/25 at 2:15 p.m., indicated the following: On 1/10/25, the council had a discussion about maintenance and the need for Resident D's heating unit to be repaired.

A current, undated facility policy, titled "Operational Guidelines for Assisted Living," was provided by the administrator on 2/7/25 at 9:56 a.m. Under the subsection B-220, the policy indicated the following: "...The residence will be kept clean and well-maintained. This will be accomplished through a regular cleaning schedule, a preventative maintenance

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	program, and repair or enhancement of existing structures, systems and fixtures...." and "...to assure that the residence remains a pleasant place to live...." This citation relates to Complaint IN00452327.			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on observation and interview, the facility failed to maintain complete and accurate records of medications administered to 1 of 3 residents reviewed for medication administration. (Residents B) Findings include: The clinical record for Resident B was reviewed on 2/5/25 at 10:06 a.m. Diagnoses included	R 0243	Residents effected: All Residents. In Service provided to clinical staff on 2/17/25. Education provided included Medication Administration Policy. Weekly EMar audits to be done by DON on designee weekly x 8 weeks, and monthly thereafter to prevent future occurrence.	02/24/2025

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hyperlipidemia, bipolar disorder, generalized anxiety disorder, hypertension, and chronic obstructive pulmonary disease.

Current physician orders for Resident B included the following:

Conjugated estrogen (hormone) 0.3 mg give one tablet by mouth at bedtime for menopausal disorder (11/3/23), torsemide 20 mg (diuretic) give one tablet by mouth once daily at noon (12/20/24), valacyclovir 500 mg - give one tablet by mouth twice daily for herpes viral infection (11/3/23), divalproex 500 mg (seizure medication) give one tablet by mouth daily (12/20/24), atorvastatin 10 mg give one tablet by mouth at bedtime for hyperlipidemia (11/3/23), buspirone 15 mg give one tablet by mouth three times a day for anxiety (11/3/23), carbidopa/levodopa 25-250 mg give one tablet by mouth twice a day for Parkinson's disease (11/3/23), oxybutynin 10 mg extended release give one tablet by mouth at bedtime for overactive bladder (11/3/23), pregabalin 100 mg (seizure medication) give one capsule by mouth three times a day (2/12/24), hydrocodone/acetaminophen 10-325 mg (opiate pain medication) give one tablet by mouth every 4 hours as directed (1/14/25), and

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hydrocodone/acetaminophen 7.5-325 mg give one table by mouth every 4 hours, with a start date of 1/27/24 and an end date of 1/17/25.

Resident B's medication administration record (MAR) was provided by the Director of Nursing on 2/7/25 at 10:29 a.m. and indicated the following:

premarin 0.3 mg tablet was not administered on 1/1/25, 1/6/25, 1/7/25, 1/12/25, and 1/17/25,

torsemide 20 mg was not administered on 1/7/25,

valacyclovir 500 mg, 8:00 p.m. dose, was not administered on 1/6/25, 1/7/25, and 1/12/25,

divalproex 500 mg was not administered on 1/6/25, 1/7/25, 1/10/25, 1/12/25, 1/15/25, and 1/17/25,

atorvastatin 10 mg was not administered on 1/6/25, 1/7/25, 1/12/25, and 1/17/25,

buspirone 15 mg, 8:00 p.m. dose, was not administered on 1/1/25, 1/6/25, 1/7/25, and 1/17/25. The 1:00 p.m. dose was not administered on 1/7/25,

carbidopa/levodopa 25-250 mg, 8:00 p.m. doses, were not administered on 1/1/25, 1/6/25, 1/12/25, and 1/17/25,

oxybutynin 10 mg was not

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administered on 1/1/25, 1/6/25, 1/7/25, and 1/12/25,

pregabalin 100 mg, 2:00 p.m. doses, were not administered on 1/6/25, 1/10/25, and 1/12/25. The 8:00 p.m. doses were not administered on 1/1/25, 1/6/25, 1/12/25, and 1/17/25,

hydrocodone/acetaminophen 10-325 mg was administered on 1/17/25 at 10:00 a.m. and 2:00 p.m.,

hydrocodone/acetaminophen 7.5-325 mg was administered on 1/17/25 at 12:00 a.m., 4:00 a.m., and 8:00 a.m. The time span between the 8:00 a.m., 7.5-325 mg dose and the 10:00 a.m., 10-325 mg dose was 2 hours. Both the 7.5-325 mg order and the 10-325 mg order were for every 4 hours.

During an interview with the DON, on 2/7/25 at 12:32 p.m., she indicated staff should be looking over orders and comparing those orders to the medication they were administering. Qualified Medication Aides (QMAs) should be documenting the medications administered in order to create a paper trail. There were potential problems, like side effects or overdose, that could occur when orders were not followed. Staff should be inserting notes when a medication was not

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administered.

During an interview with QMA 2, on 2/6/25 at 4:34 p.m., she indicated she used her judgement to know what to give, but when unsure, would contact the DON for clarification.

A current, undated, facility policy, titled "Medication Policy", provided by the administrator on 2/7/25 at 9:15 a.m., indicated the following: "Services include...maintaining written records of medication orders and supervised assistance or administration...."

This citation relates to Complaints IN00451696 and IN00452327.

Based on observation and interview, the facility failed to maintain complete and accurate records of medications administered to 1 of 3 residents reviewed for medication administration. (Residents B)

Findings include:

The clinical record for Resident B was reviewed on 2/5/25 at 10:06 a.m. Diagnoses included hyperlipidemia, bipolar disorder, generalized anxiety disorder, hypertension, and chronic obstructive pulmonary disease.

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	Current physician orders for Resident B included the following:			
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Conjugated estrogen (hormone) 0.3 mg give one tablet by mouth at bedtime for menopausal disorder (11/3/23), torsemide 20 mg (diuretic) give one tablet by mouth once daily at noon (12/20/24), valacyclovir 500 mg - give one tablet by mouth twice daily for herpes viral infection (11/3/23), divalproex 500 mg (seizure medication) give one tablet by mouth daily (12/20/24), atorvastatin 10 mg give one tablet by mouth at bedtime for hyperlipidemia (11/3/23), buspirone 15 mg give one tablet by mouth three times a day for anxiety (11/3/23), carbidopa/levodopa 25-250 mg give one tablet by mouth twice a day for Parkinson's disease (11/3/23), oxybutynin 10 mg extended release give one tablet by mouth at bedtime for overactive bladder (11/3/23), pregabalin 100 mg (seizure medication) give one capsule by mouth three times a day (2/12/24), hydrocodone/acetaminophen 10-325 mg (opiate pain medication) give one tablet by mouth every 4 hours as directed (1/14/25), and hydrocodone/acetaminophen 7.5-325 mg give one table by mouth every 4 hours, with a start date of 1/27/24 and an end date of 1/17/25.

Resident B's medication administration record (MAR) was provided by the Director of

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Nursing on 2/7/25 at 10:29 a.m.
and indicated the following:

premarin 0.3 mg tablet was not
administered on 1/1/25, 1/6/25,
1/7/25, 1/12/25, and 1/17/25,

torsemide 20 mg was not
administered on 1/7/25,

valacyclovir 500 mg, 8:00 p.m.
dose, was not administered on
1/6/25, 1/7/25, and 1/12/25,

divalproex 500 mg was not
administered on 1/6/25, 1/7/25,
1/10/25, 1/12/25, 1/15/25, and
1/17/25,

atorvastatin 10 mg was not
administered on 1/6/25, 1/7/25,
1/12/25, and 1/17/25,

buspirone 15 mg, 8:00 p.m.
dose, was not administered on
1/1/25, 1/6/25, 1/7/25, and
1/17/25. The 1:00 p.m. dose
was not administered on 1/7/25,

carbidopa/levodopa 25-250 mg,
8:00 p.m. doses, were not
administered on 1/1/25, 1/6/25,
1/12/25, and 1/17/25,

oxybutynin 10 mg was not
administered on 1/1/25, 1/6/25,
1/7/25, and 1/12/25,

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pregabalin 100 mg, 2:00 p.m. doses, were not administered on 1/6/25, 1/10/25, and 1/12/25. The 8:00 p.m. doses were not administered on 1/1/25, 1/6/25, 1/12/25, and 1/17/25,

hydrocodone/acetaminophen 10-325 mg was administered on 1/17/25 at 10:00 a.m. and 2:00 p.m.,

hydrocodone/acetaminophen 7.5-325 mg was administered on 1/17/25 at 12:00 a.m., 4:00 a.m., and 8:00 a.m. The time span between the 8:00 a.m., 7.5-325 mg dose and the 10:00 a.m., 10-325 mg dose was 2 hours. Both the 7.5-325 mg order and the 10-325 mg order were for every 4 hours.

During an interview with the DON, on 2/7/25 at 12:32 p.m., she indicated staff should be looking over orders and comparing those orders to the medication they were administering. Qualified Medication Aides (QMAs) should be documenting the medications administered in order to create a paper trail. There were potential problems, like side effects or overdose, that could occur when orders were not followed. Staff should be inserting notes when a medication was not administered.

During an interview with QMA 2,

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	on 2/6/25 at 4:34 p.m., she indicated she used her judgement to know what to give, but when unsure, would contact the DON for clarification. A current, undated, facility policy, titled "Medication Policy", provided by the administrator on 2/7/25 at 9:15 a.m., indicated the following: "Services include...maintaining written records of medication orders and supervised assistance or administration...." This citation relates to Complaints IN00451696 and IN00452327.			
R 0245	Health Services - Offense 410 IAC 16.2-5-4(e)(5) (5) Injectable medications shall be given only by licensed personnel. Based on interview and record review, the facility failed to ensure injectable medication(s) and invasive medical device(s) were administered/applied by qualified personnel for 2 of 4 residents reviewed for medication administration. (Residents B and D) Findings include: The clinical record for Resident B was reviewed on 2/5/25 at 10:06 a.m. Diagnoses included	R 0245	Residents Effected: All Residents In-Service provided on 2/17/25. Education provided to all clinical staff. Education included QMA scope of practice, and medication administration to prevent recurrence.	02/24/2025

hyperlipidemia, bipolar disorder, generalized anxiety disorder, hypertension, and chronic obstructive pulmonary disease.

A physician's order, with a start date of 11/26/24, indicated to give risperidone (antipsychotic) 37.5 mg/2 mL, inject 2 mL (milliliters) intramuscularly once daily every 14 days.

The clinical record for Resident D was reviewed on 2/6/25 at 9:30 a.m. Diagnoses included type 2 diabetes mellitus, morbid obesity, anxiety disorder unspecified, post traumatic stress disorder (PTSD), asthma, and chronic kidney disease.

Current physician's orders included Dexcom G7 (a continuous blood glucose monitor which required insertion beneath the skin), use as directed, unscheduled. Instructions - replace every 10 days (12/23/24), insulin glargine, 300 units/mL, pen injector inject 60 units subcutaneously (beneath the skin) once daily, for type 2 diabetes (12/23/24), insulin glargine, 100 units/mL, pen injector inject 60 units subcutaneously once daily for type 2 diabetes (11/13/24), and insulin lispro 100 units/mL, inject subcutaneously as directed per sliding scale before meals. Give 10 units before meals plus additional sliding scale.

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Coverage if blood glucose is above 150. If blood glucose before meal is less than 120, give 5 units; 150-199, give 2 units; 200-249, give 4 units; 250-299, give 6 units; 300-349, give 8 units; 350 and up, give 10 units (11/13/24).

The medication administration record (MAR) for Residents B and D was provided by the Director of Nursing on 2/7/25 at 10:29 a.m.

On 1/7/25, Resident B's MAR indicated the risperidone injection was administered by Qualified Medication Aide (QMA) 6.

On 1/6/25, the MAR indicated the Dexcom G7 was applied by QMA 6.

On 1/7/25, the MAR indicated the insulin glargine (60 units) was administered by QMA 6.

On 1/6/25, the MAR indicated the insulin lispro (10 units) was administered by QMA 6.

During an interview with Resident D, on 2/5/25 at 4:00 p.m., she indicated a QMA had tried to apply her Dexcom G7 continuous blood glucose monitor, but put it in the wrong place on her body and it did not work. She did not recall the date, but did remember the monitor had to be replaced. Since that time, the DON had

been applying the monitor and had given the resident instructions on how to apply it herself.

During an interview with the DON, on 2/6/25 at 1:00 p.m., she indicated most of the QMA's were certified to administer insulin. QMA 6 (no longer employed by the facility) was not certified to administer insulin.

During an interview with the DON, on 2/7/25 at 12:58 p.m., she indicated she was not aware QMA 6 had administered insulin, the risperidone, or had applied the Dexcom G7.

QMA 6 was not available for interview during the survey from February 5 through February 7, 2025.

Review of QMA 6's certification on Indiana Professional Licensing Agency website indicated she was not certified to administer insulin.

A current, undated, facility policy, titled "Qualified Medication Aide - Scope of Practice," provided by the Director of Nursing on 2/7/25 at 10:29 a.m., indicated the following: "...The following tasks shall NOT be included in the QMA scope of practice - 1) Administer medication by the injection route, including the following: A) Intramuscular

route. B) Intravenous route. C)
Subcutaneous route. D)
Intradermal route...."

This citation relates to
Complaint IN00452327.

Based on interview and record
review, the facility failed to
ensure injectable medication(s)
and invasive medical device(s)
were administered/applied by
qualified personnel for 2 of 4
residents reviewed for
medication administration.
(Residents B and D)

Findings include:

The clinical record for Resident
B was reviewed on 2/5/25 at
10:06 a.m. Diagnoses included
hyperlipidemia, bipolar disorder,
generalized anxiety disorder,
hypertension, and chronic
obstructive pulmonary disease.

A physician's order, with a start
date of 11/26/24, indicated to
give risperidone (antipsychotic)
37.5 mg/2 mL, inject 2 mL
(milliliters) intramuscularly once
daily every 14 days.

The clinical record for Resident
D was reviewed on 2/6/25 at
9:30 a.m. Diagnoses included
type 2 diabetes mellitus, morbid
obesity, anxiety disorder
unspecified, post traumatic
stress disorder (PTSD), asthma,
and chronic kidney disease.

Current physician's orders

included Dexcom G7 (a continuous blood glucose monitor which required insertion beneath the skin), use as directed, unscheduled. Instructions - replace every 10 days (12/23/24), insulin glargine, 300 units/mL, pen injector inject 60 units subcutaneously (beneath the skin) once daily, for type 2 diabetes (12/23/24), insulin glargine, 100 units/mL, pen injector inject 60 units subcutaneously once daily for type 2 diabetes (11/13/24), and insulin lispro 100 units/mL, inject subcutaneously as directed per sliding scale before meals. Give 10 units before meals plus additional sliding scale. Coverage if blood glucose is above 150. If blood glucose before meal is less than 120, give 5 units; 150-199, give 2 units; 200-249, give 4 units; 250-299, give 6 units; 300-349, give 8 units; 350 and up, give 10 units (11/13/24).

The medication administration record (MAR) for Residents B and D was provided by the Director of Nursing on 2/7/25 at 10:29 a.m.

On 1/7/25, Resident B's MAR indicated the risperidone injection was administered by Qualified Medication Aide (QMA) 6.

On 1/6/25, the MAR indicated

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the Dexcom G7 was applied by QMA 6.

On 1/7/25, the MAR indicated the insulin glargine (60 units) was administered by QMA 6.

On 1/6/25, the MAR indicated the insulin lispro (10 units) was administered by QMA 6.

During an interview with Resident D, on 2/5/25 at 4:00 p.m., she indicated a QMA had tried to apply her Dexcom G7 continuous blood glucose monitor, but put it in the wrong place on her body and it did not work. She did not recall the date, but did remember the monitor had to be replaced. Since that time, the DON had been applying the monitor and had given the resident instructions on how to apply it herself.

During an interview with the DON, on 2/6/25 at 1:00 p.m., she indicated most of the QMAs were certified to administer insulin. QMA 6 (no longer employed by the facility) was not certified to administer insulin.

During an interview with the DON, on 2/7/25 at 12:58 p.m., she indicated she was not aware QMA 6 had administered insulin, the risperidone, or had applied the Dexcom G7.

QMA 6 was not available for

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OMB NO. 0938-0391

interview during the survey from February 5 through February 7, 2025.

Review of QMA 6's certification on Indiana Professional Licensing Agency website indicated she was not certified to administer insulin.

A current, undated, facility policy, titled "Qualified Medication Aide - Scope of Practice," provided by the Director of Nursing on 2/7/25 at 10:29 a.m., indicated the following: "...The following tasks shall NOT be included in the QMA scope of practice - 1) Administer medication by the injection route, including the following: A) Intramuscular route. B) Intravenous route. C) Subcutaneous route. D) Intradermal route...."

This citation relates to Complaint IN00452327.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR
PROVIDER/SUPPLIER REPRESENTATIVE'S
SIGNATURE

TITLE

(X6) DATE